American International Companies®

PROOF OF LOSS

A&H Claims Department
P. O. Box 15701
Wilmington, DE 19850-5701
800-551-0824/302-761-3700

NAME OF GROUP: Kentucky Vocational Tech School

POLICY NUMBER: SRG 805 1702
AIG Life Company

SPECIAL RISK ACCIDENT AND SICKNESS CLAIM FORM

INSTRUCTIONS:

1.) You must have SECTION A fully completed by a designated official of the Policyholder.
2.) SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
3.) If claimant is treated in the hospital, please attach an itemized hospital bill.
4.) If claimant is treated by a doctor, have the doctor complete the Physician's Statement or attach an itemized bill.
5.) Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service.
6.) Please mail completed form and bills to above address.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A

LOCATION OF GROUP POLICYHOLDER

CLAIMANT'S FULL NAME	SOCIAL SECURITY NO. (IF AVAILABLE)	DATE OF BIRTH	NAME OF SUPERVISOR

DATE COVERAGE BEGAN	DATE COVERAGE WILL END/HAS ENDED

NATURE OF INJURY OR ILLNESS. (DESCRIBE FULLY. INCLUDING WHICH PART OF BODY WAS INJURED.)	DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME).

NAME OF ACTIVITY	DID ACCIDENT OCCUR:		
	A. WHILE CLAIMANT WAS SUPERVISED	☐ YES	☐ NO
	B. DURING SPONSORED ACTIVITY	☐ YES	☐ NO
INDICATE THE SPORT (IF APPLICABLE)	C. DURING PROGRAMMED HOURS	☐ YES	☐ NO
	D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	☐ YES	☐ NO

DATE LAST WORKED	DATE RETURNED TO WORK	WEEKLY EARNINGS

POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE) TITLE	DAYTIME TELEPHONE NUMBER
	( )

SIGNATURE OF POLICYHOLDER REPRESENTATIVE — DATE

SECTION B

NAME OF CLAIMANT (PARENT OR GUARDIAN IF A MINOR)	DAYTIME TELEPHONE NO.
	( )

ADDRESS OF CLAIMANT (PARENT OR GUARDIAN IF A MINOR)

OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF INSURED, NAME AND ADDRESS OF INSURANCE COMPANY, NAME OF EMPLOYER AND POLICY NUMBER.)
YES ____ NO ____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.
SIGNATURE (CLAIMANT OR PARENT, IF CLAIMANT IS A MINOR) — DATE

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE — DATE

Section B

HEALTH INSURANCE CLAIM FORM

CLAIMANT INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS CHAMPVA GROUP HEALTH PLAN ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER

2. PATIENT'S NAME (First Name, Middle Initial, Last Name)

3. PATIENT'S DATE OF BIRTH MM / DD / YY SEX M ☐ F ☐

4. INSURED'S NAME (First Name, Middle Initial, Last Name)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ (SPECIFY)

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE NO. ( )

ZIP CODE | TELEPHONE NO ( )

9. OTHER INSURED'S NAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

A. OTHER INSURED'S POLICY OR GROUP NUMBER

A. PATIENT'S EMPLOYMENT? YES ☐ NO ☐

3. PATIENT'S DATE OF BIRTH MM / DD / YY SEX M ☐ F ☐

B. OTHER INSURED'S DATE OF BIRTH MM / DD / YY SEX M ☐ F ☐

B. AN AUTO ACCIDENT? YES ☐ NO ☐

B. EMPLOYER'S NAME OR SCHOOL NAME

C. EMPLOYER'S NAME OR SCHOOL NAME

C. OTHER ACCIDENT? YES ☐ NO ☐

C. INSURANCE PLAN NAME OR PROGRAM NAME

D. INSURANCE PLAN NAME OR PROGRAM NAME

D. RESERVED FOR LOCAL USE

D. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to & complete item 9 A-D

12. PATIENT'S OR AUTHORIZED PERSONS' SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature _____ Date _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to undersigned physician or supplier for service described below.

Signature _____ Date _____

14. DATE OF CURRENT: MM / DD / YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE: MM / DD / YY

16. Dates Patient Unable To Work in Current Occupation MM / DD / YY FROM / / TO MM / DD / YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. Hospitalization Dates Related to Current Services MM / DD / YY FROM / / TO MM / DD / YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1 _____ 3 _____

2 _____ 4 _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE FROM MM/DD/YY	TO MM/DD/YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H DPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO

27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE #

PIN# GRP#

PLACE OF SERVICE CODES

1-(H) - INPATIENT HOSPITAL
2-(OH) - OUTPATIENT HOSPITAL
3-(O) - DOCTOR'S OFFICE
4-(H)-PATIENT'S HOME
5- -DAYCARE FACILITY (PSY)
6- -NIGHT CARE FACILITY(PSY)
7-(NH) NURSING HOME
8-(SNF)-SKILLED NURSING FACILITY
9- -AMBULANCE
O-(OL)-OTHER LOCATIONS
A-(IL)-INDEPENDENT LABORATORY
B- -OTHER